



PATHWAYS TO INSTITUTIONAL CARE FOR ELDERLY INDIGENOUS AFRICANS: NAVIGATING CONTOURS OF ALTERNATIVES

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ABSTRACT

The study sought to explore factors resulting in institutionalisation of elderly indigenous Africans in Zimbabwe. Though Africans value ageing-in-place, in the comfort of familiar people and surroundings, some are institutionalised despite negative outcomes on well-being. A qualitative case study was conducted using total population sampling to select nine residents. The mean age was 69 while mean duration in institutional care was four years. Unstructured interviews with the elderly, and a structured interview with the purposively sampled matron, were used. Data was narrated and thematically analysed. Findings suggested that institutionalisation emanated from adverse socio-economic factors, which impacted on health. Lack of close family ties, and dire poverty led to destitution and to failure to purchase drugs. These factors acted individually and in complex interactive ways, forming a pattern of problems. Institutional care was appreciated with reservations. The results imply that there is need to strengthen family support systems so that institutionalisation only serves those without alternative living arrangements.

KEY TERMS: indigenous Zimbabwean, institutional care, elderly, old age home

INTRODUCTION AND BACKGROUND

Indigenous Zimbabweans value ageing-in-place, in the comfort of familiar people and surroundings (Hungwe, 2011). The belief is that the elderly, aged 60 and above (United Nations [UN], 2015) remain in the community, living in their own homes, or living with and getting help from kin. However, some indigenous elderly Africans are institutionalised. Thus, according to Tran (2012), institutionalisation invokes in these elderly, negative feelings of regret, powerlessness, guilt and neglect. Dhemba and Dhemba (2015) comment that institutionalisation of elderly Africans is shunned and is only adopted as a last resort as it is against the expected role of families to care for their elderly. It is in view of the perceived preference to age-in-place versus institutional care that the study sought to explore factors leading to institutionalisation of elderly indigenous Africans.

The elderly need care as their personal activities get limited by developmental challenges resulting with a degeneration of health, disability, frailty, and incapacity for self-care (Levinson, 2008). Therefore, old age calls for decisions about where and with whom to live, and this is influenced by cultural traditions and values (Papalia et al, 2004). Thus, many factors shape, sustain and transform the elderly's living arrangements, which include migratory status, availability of children and resources, sex, family size and marital, financial and health status of both the elderly and their kin, current and past emotional bonds and shared experiences. Traditionally, the extended family's multi-generational household has always been the single most important source of care in Sub-Saharan Africa (Madungwe et al, 2011). Boggatz (2011) adds that Africans have always banked on the strength of traditional family solidarity.

However, according to Dhemba (2013), care provision by kin is strained: the potential caregivers, also being the most productive age-group of 21 to 49 (UN, 2015), die of HIV/AIDS, and Sub-Saharan Africa remains the hardest hit. Secondly, Kaseke and Dhemba (2007) also argue that previously built-in safety-nets have been disrupted by the weakening of traditional social ties and obligations, by the emergence of new forms of socio-political control, new religions and family structures, globalization, industrialization and urbanization, all of which undermine traditional extended family systems and promote individualism and waning of gerontocracy's power and status. Thirdly, elderly Africans previously wielded considerable power, privilege and influence within high social hierarchies, and traditionally, they controlled spiritual matters, religion, and strategic and valuable resources such as land, food and livestock, and this made families look up to them and provide them with social security. Also, the elderly's honor and respect kept families and communities together and this guaranteed later support (Rwezaura, 1989).

Failure to age-in-place results with institutionalisation, which is an emergence of a new era, that is alien to Africans (Hungwe, 2011). Yet the UN (2015) posits that general care for the elderly is likely to increase as the world is ageing at an unprecedented rate, and in 2010, 6% of 12 523 million Zimbabweans were the elderly, and this population is projected to double in 2050. Thus, the need for institutional care is further exacerbated by the fact that two thirds of the world's elderly live in poverty in Africa.

Dhemba (2013) explains the conspicuous presence of foreigners in Zimbabwean old age homes. The author points out that the large numbers of institutionalized foreigners are due to the relationship that existed between the then Rhodesia and 2 countries, Mozambique and Malawi, which supplied a migratory workforce, most of who were young men who came to make an income and toiled under very harsh conditions: The consequence was that by 1974 there were 79 978 African foreign males and 8 048 females employed as domestic servants on estates, farms, in mines, and in manufacturing industries (Dhemba, 2013). Now in their old age, most (non)immigrants are now incorporated into extended family arrangements.

In addition, Madungwe et al. (2011) posit that in most Sub-Sahara African countries, centrally-developed systems for income security in old age were extremely limited for blacks during the colonial era, particularly for low-paying jobs in the informal sector. Native retirees were expected to return to their rural homes, and this colonial policy only worked for Zimbabweans. The policy of repatriation also shifted the costs of retirement onto the retirees' countries of origin. In addition, the World Bank (2004) estimates that over 70% of the world's elderly rely on informal systems of security, especially in developing countries, including Sub-Saharan Africa.

It is against the given background that the study sought to explore reasons that led to the elderly indigenous Africans being institutionalized. Awareness of such reasons could have a decisive role in designing interventions and to improve preferred living arrangements. Thus, the study's objectives were to explore social, economic and health-related reasons of institutionalization of elderly indigenous Africans; and to analyse elderly indigenous Africans' perceptions about continued institutionalisation.

THEORETICAL FRAMEWORK

The study was guided by Goffman's 1961 total institution theory, which explains the elderly's social world and their subjective lived experiences before and after being institutionalized, and these are aspects that were in line with the problem under study. Basing on this theory, the elderly's past social life brought out reasons for them having been under institutional care, and that they had negative experiences while institutionalized hence explaining the need for having alternative choices besides institutional care

Ritzer (2007) describes a “total institution” as a place of residence and/or work, which houses like-situated people, cut off from society for a period of time, and who together lead a formally-administered orderly routine. In defining the concept of “total institution”, Ritzer (2007) gives the theory’s main argument, which is that it delineates the key features of totalitarian social systems. Such systems encompass the residents’ whole being by undercutting their individuality, disregarding their dignity, and subjecting them to a regimented pattern of life that has little to do with their own desires or inclinations.

Clark and Bowling (1990) analyse the total institution theory, and say that its strength lies in that total institutions have common distinguishing characteristics, which make the concept a useful and enduring one. The characteristics depart from the basic social arrangements that individuals experience a breakdown in the barriers that ordinarily separate sleep, play and work which should occur in different places with different co-participants under different authorities and without an overall rational plan to fulfill official aims of any institution. These combined various spheres of life are a central feature of total institutions hence Goffman’s use of the term “total institution” has several dimensions.

However, the total institution theory has some weaknesses (Clark & Bowling, 1990), the first of which is that total institutions are not as homogeneous as Goffman portrays them because they differ depending on the services they offer. Secondly, the concept of “total institution” has a tight definition, which cannot be stretched with impunity. Lastly, not all total institutions are as oppressive and as opposed to individuals as Goffman suggests.

In the current study, total institutions were old age homes, about which Dhemba (2013) says that they alter personalities of the elderly, dehumanize, dominate, overpower, and determine their lives. Thus, the elderly have also to adjust through loss of social status, lack of autonomy, habitual activities and social contacts. Dhemba and Dhemba (2015) also comment that institutionalization de-personifies, causes loss of privacy and autonomy, and long-term institutional care creates an institutional personality syndrome whereby the elderly get disoriented, disorganized, withdrawn, apathetic, depressed, resigned and hopeless.

METHODOLOGY

Design

A qualitative case study design was used with an unstructured interview, whose open-ended questions enabled the elderly to narrate their life histories that encompassed reasons that led to institutionalisation, and how they perceived their continued stay in the home. The in-depth data was given in the elderly’s own words. Also administered was a structured interview with the matron so as to complement the elderly’s responses.

Participants

The study was conducted at an old age home in Gweru, Zimbabwe’s Midlands Provincial capital city. At the time of study, the home housed 9 elderly indigenous Africans. Total population sampling enabled the entire elderly population to participate. The matron was purposively selected as she was the longest-serving of the 3 staff members, and hence was the most knowledgeable about institutionalisation.

Data collection procedure

In observing anonymity, real names of the old age home and of the elderly were concealed. Hence the elderly were addressed with titles *Mbuya* and *Sekuru*, which are honorific terms for grandmother and grandfather respectively. Other ethics observed were informed consent, confidentiality and privacy. Pre-testing was done to increase credibility and dependability of questions. The interviews were conducted in the local Shona language, and responses were translated to English.

Data analysis procedure

Interview data was narrated, and thematically analysed following Zhang and Wildemuth’s (2005) stages, namely familiarization, conceptualization, cataloguing of concepts, reviewing themes and defining them. Because interview questions were guided by research objectives, the sub-themes revolved around these objectives. Themes that emerged as reasons for being institutionalised were lack of close family ties, destitution which resulted with dire and chronic poverty, and developmental challenges, and there was also dislike for institutionalisation.

RESULTS

At the beginning of each interview, questions on the elderly’s demographic data were asked regarding their age, gender, marital status, duration of stay in the home, and nationality. Information that emanated from these questions was useful in that it showed variables that could explain reasons for the elderly being institutionalised.

Regarding age, the younger ones could have been institutionalized for reasons other than those related to old age. The gender and marital status could have indicated desperate situations needing institutionalisation, such as single men or women not being able to do daily chores for self-upkeep in the absence of help from spouses. The elderly's duration of stay in the home could have had implications on the elderly's lived experiences. Those who had stayed longer were likely to express broader lived experiences in the home, and probable willingness for continued stay. Lastly, the elderly's nationality could imply the need for institutionalisation as being foreigners, away from close family, might have resulted with lack of family psychosocial support needed in old age. Table 1 shows the participants' demographic data.

Table 1: Demographic characteristics of participants

Name	Age	Gender	Marital status	Duration (years)	Nationality
A	70	male	widowed	1	Zimbabwe
B	Unknown	male	widowed	3	Malawi
C	63	male	widowed	3	Malawi
D	Unknown	female	widowed	5	Swaziland
E	79	male	widowed	4	Malawi
F	85	male	widowed	6	Malawi
G	85	male	widowed	8	Malawi
H	Unknown	female	widowed	3	Malawi
I	Unknown	male	widowed	2	Mozambique

The mean age of the elderly was 69 years, and the mean duration of stay in the home was 4 years. All the 9 elderly were widowed and 7 of them were males. There was only one Zimbabwean, and the rest were foreigners comprised of one Swazi, one Mozambican, and six Malawians. Therefore, this demographic data could imply that the current study's findings were greatly influenced by views of old and widowed male foreigners.

The following section is on reasons for the elderly being institutionalised, and these are narrated guided by themes and respective sub-themes that emerged from the interviews. The reasons are important in that they reflect views expressed by most of the elderly in their responses to questions relating to their reasons for being institutionalized. They were social, economic and health-related. Other sub-themes were also related to the elderly's views about their continued stay in the institution. Table 2 shows themes and respective sub-themes based on factors for institutionalization.

Table 2: Themes and sub-themes

Themes	Sub-themes
No close family ties	Widowed No surviving children Lost ties with kin Uncordial relationships with kin
Destitution: dire, chronic poverty	Hunger, inadequate clothing Homelessness: Unpaid rentals, water and electricity bills Failure to purchase drugs
Developmental challenges	Visual impairment Chronic ailments
Dislike of continued stay	No other option No belongingness Dislike foreign burial

The first theme is on social factors of institutionalisation that mostly pointed at lack of close family ties, which were demonstrated by the elderly reporting being widowed, having no children to care for them, having lost ties and/or uncordial relationships with kin. The second theme is on economic factors, which resulted with destitution as indicated by the elderly reporting having suffered dire and chronic poverty as evidenced by having inadequate food and clothing. The third theme is on health-related factors, which were partly linked to developmental frailty due to old age, such as poor sight and chronic ailments, and/or due to illnesses mostly emanating from harmful previous work experiences, and current life-styles. Lastly, is the theme on the elderly's dislike of continued stay in the home as was illustrated by their expressions of lack of other suitable living arrangements, lack of sense of belonging to the home, and shunning being buried by foreigners on foreign land.

Theme 1: No close family ties

All the nine elderly reported lack of close family due to death or unmaintained or severed relationships. Sekuru C sadly said *"My first wife died back in Malawi. I re-married a Zimbabwean, who also later died"*. This was supported by Sekuru A who said *"My wife and I were farm laborers but she later died"*. While he said this, Sekuru A was shaping a circle on the floor with his walking stick. Other participants had related experiences. *"I met my late Zimbabwean husband in Swaziland. We then came to Zimbabwe where he later died"*. (Mbuya D). The matron said, *"All these elderly people are widowed"*.

Seven of the elderly reported having no children. *"My 3 sons never returned from the Chimurenga war of liberation"*, and *"I lost 9 of my 10 children to HIV/AIDS"*, said Sekuru A
"My only 2 children died at tender ages". (Mbuya D)

Five of the elderly reported having lost kin contacts. Mbuya D said *"I lost contact with my family in Swaziland. Unfortunately my Zimbabwean in-laws never approved me marrying their son. So I am all by myself"*. While Sekuru F commented *"I have no idea where my 8 children are and I doubt that they want to have anything to do with me. They were very young when I left Malawi and sadly, I never remitted any money"*. Sekuru G commented *"When my late Mozambican wife died, her relatives took my 2 very young children with them. I never saw them since then and don't know where to look"*. The Matron said *"These foreigners completely forgot about their families back home, and most co-habited with Zimbabwean women. This is why they neither have strong family ties here nor there. People they call 'relatives' are actually their fellow countrymen"*.

Seven of the elderly had severed relationships with their kin. *"I had 2 children with my late Zimbabwean wife, but we last met years back. They became bitter and unruly, with no regard for me as their father, suspecting my late Mozambican wife of bewitching their mother. As far as I am concerned, they do not exist"*. As he said this, Sekuru G was frowning, and Sekuru A also said *"On retiring, I moved in with my 2 grand-sons but relational problems started when they later married"*. Mbuya H said *"My late husband decided to return to Malawi with our 3 young children, who persuaded me to join them after he later died but I had re-married a Zimbabwean man. They vowed to never have anything to do with me"*.

Theme 2: Destitution

Seven of the elderly had voluntarily sought institutional care or had been picked from the streets by Social Welfare officers or by the Police due to dire and chronic poverty. While puffing his home-made cigarette, Sekuru I said: *"After retiring, I went for days without proper meals, and had inadequate clothing"* while Sekuru F said *"At first I sold my home items to raise money for food but soon there was nothing more to sell"*. Showing disbelief, Sekuru B said: *"My former white employer relocated to South Africa and the new house- owner demanded rentals for the cottage where I stayed. I sold my belongings and only raised 1 month's rentals then ended up a squatter"*, and the Matron reiterated *"Before being admitted into the home, most of the elderly lived in shacks, under squalid conditions"*.

Six of the elderly reported failure to afford drugs and fares to and from health-care centres. This is illustrated by Sekuru B, who said *"I could not purchase medication and my health worsened. I later moved in with my brother's family, who also struggled in caring for me as I was continuously hospitalised"*. In agreement, the Matron said *"These elderly had long stopped taking drugs due to lack of funds."*

Theme 3: Illnesses

The matron reported various ailments among the elderly. While three had mild ones, two were developmentally incapacitated and four had chronic illnesses. All the elderly often sought herbs from Sekuru A, who said *"I stopped working after I failed to see and fell into a home-made well, and my dislocated pelvic joint never recovered"*. *"I lost my job when it became difficult to execute my duties since I could no longer move around on my own. My sight has worsened"*, said Mbuya D, emptily gazing into space.

Chronic ailments were reportedly a result of previous jobs and/or current lifestyles. *“Farm pesticide vapors damaged my lungs. I’ve been advised against my chimonera [home-made cigarette] but I can’t do without it”,* wizzed Sekuru B. *“My most persistent ailments are arthritis, hypertension and diabetes. I was unconscious when Social Welfare personnel picked me from the streets”,* said Sekuru G.

Theme 4: Dislike of continued stay

All the elderly expressed appreciation for institutional care but most expressed mixed feelings. Four of the elderly reported that life in the home was far better than out there but that it was only best as a last resort, and therefore considered it as their last place of residence. *“I feel at home as I explore my hobbies of working on my portion of land, fishing, setting rabbit traps to supplement my relish, and strolling. But I imagine what life would be like under normal circumstances”,* said Sekuru C, smiling, and Sekuru E commented *“I can’t complain but only wish things could be otherwise”. “They often seat on benches, are quiet, reminiscing, story-telling, or sleeping”,* retorted the Matron.

Five of the elderly were satisfied with continued stay in the home but wished to be repatriated for failure to connect with the home. This is illustrated by Sekuru B and F who respectively said *“There’s something I miss about Malawi”. “Home is always best. I will grab the earliest opportunity to return to Malawi”.* However, the Matron commented *“They want to go back where? Most can’t even give accurate information of the whereabouts of their families to enable repatriation”.*

The older elderly feared improper burials as illustrated by Sekuru F, who grimaced as he said *“I have had my stint in Zimbabwe and it’s time to go back. I disdain a pauper’s burial on foreign land”. “I have deliberated about my discharge. I can earn a living through traditional healing”,* said Sekuru A. *“Those wishing to be repatriated are assisted by their respective countries’ Ambassadors, who first locate their relatives to avoid repeated destitution”* (Matron).

DISCUSSION

The elderly’s mean age was 69. While the duration of stay in the home was 4 years, foreign residents’ average duration of stay in Zimbabwe was 45 years, which could imply that most came to Zimbabwe when they were very young. Foreigners dominated the home’s population because old immigrants are far away from their kin, and males outnumbered females due to the colonial legacy of labor migration which promoted males (Gutsa and Chingarande, 2009). All the elderly had previously been engaged in unskilled work, and 6 reported at least 1 chronic ailment: In concurrence is Goffman’s 1961 total institution theory, which explains the elderly’s previous social world, of having been negatively impacted on by unskilled work, as the source of a plethora of reasons that resulted in them being under institutional care; The theory also refers to the elderly’s negative subjective lived experiences while under institutional care, which explains the need to consider alternative choices.

The current study investigated factors of institutionalization of elderly indigenous Africans. Results showed a combination of social and economic factors, with health factors mostly being impacted on by the later.

Social factors

Findings suggested negative social causes of institutionalisation. In support of lack of close family ties, are Madungwe, et al. (2011), who posit that institutionalisation is often due to death of spouses and of HIV/AIDS-related deaths of children. In further concurrence, is Hungwe’s (2011) Zimbabwean study’s findings which showed that institutionalization was for those without kin or those who could not locate them or with whom there were severed relationships. In addition, Knal’s (2009) US study had older Afro-Americans reporting that institutionalisation was indicative of lack of sound family ties. In Lan’s (2002) view, some elderly seek institutional care to get relief from abandonment and rejection by their kin due to sour or weakened relationships. Chen (2011) also adds that most elderly African migrants had left their families in their countries of origin.

Economic factors

Adverse economic factors resulted in institutionalisation. In concurrence is Madungwe et. al.’s (2011) Masvingo study, whose findings revealed dire and chronic poverty among the elderly. Hungwe’s (2011) Zimbabwean study also had elderly indigenous Africans stating abject poverty as the major reason. In addition, Hutton’s (2008) analysis of the Poverty Assessment Survey’s findings showed that 80% of elderly Africans were very poor. Gutsa and Chingarande (2009) also posit that institutionalized Africans are mostly former labor migrants, who become destitute.

Health-related factors

Findings showed that ill health alone was not the reason for institutionalisation but lack of funds to purchase drugs and/or to travel to health-care centres. In lending credence to these findings is Tran (2012), who comments that financial security, alongside health care, is cited by the elderly as among their most urgent concerns. Hungwe's (2009) study also found that most of the elderly had developmental challenges exacerbated by their current or past unhealthy lifestyles or occupations such as alcoholism, smoking and work-related toxic industrial and mine wastes, fumes or vapors. However, their main reasons for seeking institutional care were food and shelter. The current findings that the elderly had ailments, is supported by the Zimbabwe Population Census' (2012) Report, which states that 17% of the aged reported having at least 1 disability, and that sensory impairments accounted for more than 40% of their disabilities.

Perceptions of continued stay

Findings showed mixed feelings about continued stay in the home due to concerns about the future. In agreement is Kimondo's (2012) Finland study which had some elderly regarding the home as their last place of residence, being the only living arrangement available. Also, Knal's (2009) US study found that most elderly Latinos had difficulties in referring to the institution as their home due to lack of meaning to their life roles. In further concurrence is Hungwe's (2011) study whose findings were that older persons expressed boredom, powerlessness and hopelessness because of an unstimulating environment. Chang's (2013) study also showed that institutionalized elderly were anxious about their future as they witnessed fellow residents falling sick and dying.

Further current findings were that the elderly wished to get proper burial in their countries of origin. In concurrence is Chipangura (2016), who posits that for burial to be considered proper, honorable, meaningful and acceptable in most African traditional cultures, the dead should be buried by their own people, on their ancestry land: Burial rituals in Africa are believed to ensure the deceased are properly put to rest for their spirits to be at peace and for them to take their rightful place among their protective ancestors.

IMPLICATIONS AND LIMITATIONS

Findings showed the elderly's preference to age-in-place. This suggests that family support systems will and must continue to provide care for the elderly. Thus, sources of psychosocial support could strengthen families that struggle with the required care. Because most participants were Malawians, their perceptions influenced this study's findings which therefore, may not be generalized to all old age homes in Zimbabwe. However, the findings may be reflective of the factors of institutionalisation in similar homes. Further research could be conducted on confounding variables, and on protective factors that could explain non-institutionalisation of some elderly facing similar identified factors.

CONCLUSION

Reasons for institutionalisation of elderly indigenous Africans were negative social aspects, which resulted with no kin to provide care as indicated by all the elderly being widowed, some having no surviving children, and others having long-lost ties with their kin or having unsound relationships with them. Dire and chronic poverty also resulted with destitution as evidenced by reports of hunger, inadequate clothing and failure to purchase medicinal drugs, and to pay rentals, water and electricity bills. Health-related issues were evidenced by reported ailments. Thus, the study's findings suggested a syndrome of problems, all of which acted in their individual capacities and in complex interactive ways, which resulted in institutionalisation.

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